

each encounter between a Medicare enrollee and a provider, supplier, physician, or other practitioner.

(b) *Types of service and timing of submission.* M+C organizations must submit data as follows:

(1) Beginning on a date determined by HCFA, inpatient hospital care data for all discharges that occur on or after July 1, 1997.

(2) HCFA will provide advance notice to M+C organizations to collect and submit data for services that occur on or after July 1, 1998, as follow:

(i) Physician, outpatient hospital, SNF, and HHA data beginning no earlier than October 1, 1999; and

(ii) All other data HCFA deems necessary beginning no earlier than October 1, 2000.

(c) *Sources and extent of data.* (1) To the extent required by HCFA, the data must account for services covered under the original Medicare program, for Medicare covered services for which Medicare is not the primary payor, or for other additional or supplemental benefits that the M+C organization may provide.

(2) The data must account separately for each provider, supplier, physician, or other practitioner that would be permitted to bill separately under the Medicare fee-for-service program, even if they participate jointly in the same encounter.

(d) *Other data requirements.* (1) M+C organizations must submit data that conform to the requirements for equivalent data for Medicare fee-for-service when appropriate, and to all relevant national standards.

(2) The data must be submitted electronically to the appropriate HCFA contractor.

(3) M+C organizations must obtain the encounter data required by HCFA from the provider, supplier, physician, or other practitioner that rendered the services.

(4) M+C organizations may include in their contracts with providers, suppliers, physicians, and other practitioners, provisions that require submission of complete and accurate encounter data as required by HCFA. These provisions may include financial penalties for failure to submit complete data, or for failure to submit data that

conform to the requirements for equivalent data for Medicare fee-for-service.

(e) *Validation of data.* M+C organizations and their providers and practitioners will be required to submit medical records for the validation of encounter data, as prescribed by HCFA.

(f) *Use of data.* HCFA uses the data obtained under this section to determine the risk adjustment factor that it applies to annual capitation rates under § 422.256(c). HCFA may also use the data for other purposes.

(g) *Deadlines for submission of encounter data.* Risk adjustment factors for each payment year are based on encounter data submitted for services furnished during the 12 month period ending 6 months before to the payment year (for example, risk adjustment factors for CY 2000 are based on data for services furnished during the period July 1, 1998 through June 30, 1999).

(1) The annual deadline for encounter data submission is September 10 for encounter data reflecting services furnished during the 12 month period ending the prior June 30 (for example, the deadline for submission of data for the period July 1, 1998 through June 30, 1999 is September 10, 1999).

(2) HCFA allows a reconciliation process to account for late data submissions. HCFA continues to accept encounter data submitted after the September 10 deadline until June 30 of the payment year (for example, until June 30, 2000 for data from the period July 1, 1998 through June 30, 1999). After the payment year is completed, HCFA recalculates the risk factors for affected individuals to determine if adjustments to payments are necessary.

[63 FR 35090, June 26, 1998, as amended at 65 FR 40326, June 29, 2000]

**§ 422.258 Announcement of annual capitation rates and methodology changes.**

(a) *Capitation rates.* (1) No later than March 1 of each year, HCFA announces to M+C organizations and other interested parties the capitation rates for the following calendar year.

(2) HCFA includes in the announcement a description of the risk and other factors and explains the methodology in sufficient detail to enable

M+C organizations to compute monthly adjusted capitation rates for individuals in each of its payment areas.

(b) *Advance notice of changes in methodology.* (1) No later than January 15 of each year, HCFA notifies M+C organizations of changes it proposes to make in the factors and the methodology it used in the previous determination of capitation rates.

(2) The M+C organizations have 15 days to comment on the proposed changes.

**§ 422.262 Special rules for beneficiaries enrolled in M+C MSA plans.**

(a) *Establishment and designation of medical savings account (MSA).* A beneficiary who elects coverage under an M+C MSA plan—

(1) Must establish an M+C MSA with a trustee that meets the requirements of paragraph (b) of this section; and

(2) If he or she has more than one M+C MSA, designate the particular account to which payments under the M+C MSA plan are to be made.

(b) *Requirements for MSA trustees.* An entity that acts as a trustee for an M+C MSA must—

(1) Register with HCFA;

(2) Certify that it is a licensed bank, insurance company, or other entity qualified, under sections 408(a)(2) or 408(h) of the IRS Code, to act as a trustee of individual retirement accounts;

(3) Agree to comply with the M+C MSA provisions of section 138 of the IRS Code of 1986; and

(4) Provide any other information that HCFA may require.

(c) *Deposit in the M+C MSA.* (1) The payment is calculated as follows:

(i) The monthly M+C MSA premium is compared with  $\frac{1}{12}$  of the annual capitation rate for the area determined under § 422.252.

(ii) If the monthly M+C MSA premium is less than  $\frac{1}{12}$  of the annual capitation rate, the difference is the amount to be deposited in the M+C MSA for each month for which the beneficiary is enrolled in the MSA plan.

(2) HCFA deposits the full amount to which a beneficiary is entitled under paragraph (c)(1)(ii) of this section for the calendar year, beginning with the

month in which M+C MSA coverage begins.

(3) If the beneficiary's coverage under the M+C MSA plan ends before the end of the calendar year, HCFA recovers the amount that corresponds to the remaining months of that year.

**§ 422.264 Special rules for coverage that begins or ends during an inpatient hospital stay.**

(a) *Applicability.* This section applies to inpatient services in a "subsection (d) hospital" as defined in section 1886(d)(1)(B) of the Act.

(b) *Coverage that begins during an inpatient hospital stay.* If coverage under an M+C plan offered by an M+C organization begins while the beneficiary is an inpatient in a subsection (d) hospital—

(1) Payment for inpatient services until the date of the beneficiary's discharge is made by the previous M+C organization or original Medicare, as appropriate.

(2) The M+C organization offering the newly-elected M+C plan is not responsible for the inpatient services until the date after the beneficiary's discharge; and

(3) The M+C organization offering the newly-elected M+C plan is paid the full amount otherwise payable under this subpart.

(c) *Coverage that ends during an inpatient hospital stay.* If coverage under an M+C plan offered by an M+C organization ends while the beneficiary is an inpatient in a subsection (d) hospital—

(1) The M+C organization is responsible for the inpatient services until the date of the beneficiary's discharge;

(2) Payment for those services during the remainder of the stay is not made by original Medicare or by any succeeding M+C organization offering a newly-elected M+C plan; and

(3) The M+C organization that no longer provides coverage receives no payment for the beneficiary for the period after coverage ends.

**§ 422.266 Special rules for hospice care.**

(a) *Information.* An M+C organization that has a contract under subpart K of this part must inform each Medicare enrollee eligible to elect hospice care